

Study of symptom management strategies for palliative care nursing essay



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This essay revolves around Claire, her symptoms, her ability to cope as well as her husband Andrew. More precisely, it will focus on strategies which can be employed for symptom management.

Central to any form of management strategy for Claire is a holistic assessment of her circumstances followed by planning, implementation and evaluation. This can often be accomplished by with the assistance of an assessment model which are all, to a large extent, broadly based on this plan, but each can analyse the problem from a different perspective.

(Fawcett J 2005)

If one first considers the situation under the aegis of the Roper Logan Tierney model (Roper, Logan & Tierney 2000), this model analyses the major issues of patient management in terms of solving the patient's difficulties in adapting to and coping with daily living, particularly if such coping is affected by either a physical disability or a disease process. In terms of those with malignant disease, this is clearly one of their major issues. Even a brief overview of the literature demonstrates that this model is extensively utilised and is possibly one of the most widely accepted models of patient

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management (Holland, Jenkins, Solomon & Whittam 2003). One of the major weakness of this model can be seen in the fact that it is not particularly effective in producing management strategies that can be effective in dealing with patients who are frankly manipulative or are presenting with symptoms that are overtly psychological in nature. Whilst there is no suggestion that Claire is overtly manipulative, Johnson points to the fact that the management of psychological issues in palliative care is every bit as central to a successful outcome, as dealing with ostensibly more obvious symptom features such as pain control (Johnson 1999.)

Management of such patients can be better if the healthcare professional views such functional behaviour as a adaption process to the illness role as described by the Roy adaption model. (Roy 1991) which seeks to describe patient behaviour in terms of the ability of the patient to adapt to whatever stimulus is generating the behaviour. In the case of the patient with malignant disease, knowledge of a terminal diagnosis is a potent stimulus for behaviour change.

Utilisation of this model allows for the nursing management decisions to respond to the evolving trajectory of the illness. This model can prove useful insofar as it determines why the patient tends to exhibit different behaviour patterns or coping strategies in response to their illness trajectory but it is of no real value in circumstances where a patient enters a period of overt denial of their terminal situation. To use Claire as a case in point, it would appear that she is presenting her symptoms individually rather than as part of a spectrum associated with the primary pathophysiological cause. It is not uncommon, in such circumstances, for a person to present with an illness
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that is obviously terminal, but who insists on trying to continue their daily life pattern as if there was no immediate problem.

To a degree, her expression of surprise at the fact that people have “ come out of the woodwork” to visit her is an demonstration of this fact. In contrast to the other two models discussed, the adaption model would describe this as a variety of cognitive distortion rather than overt denial. Clearly the patient cannot adapt to something that they are choosing not to overtly confront. (Steiger & Lipson 2005) Claire appears to be somewhere between these two eventualities. Obviously she is aware of her diagnosis, but is expressing surprise that people would suddenly want to visit her. The Johnson’s behavioural model would probably be the most appropriate for this scenario as Claire’s behaviour pattern will almost certainly change as her symptomatology progresses. It follows that one has to take a view on the specific causation of the symptoms before one can take a rational view of the evidence base supporting any management strategies.

Prior to the active consideration of the management of the symptoms, in the context of the behavioural model of patient management, one must comment on the huge spectrum of skills and requirements that are currently expected of the modern professional nurse. Yura et al. state, in their authoritative overview paper, that to be functional and effective the nurse must “ understand the human condition from the viewpoint of the pathophysiology, the psychology, the human dynamic and socio-economic elements of the patient’s presentation and disease trajectory “. (Yura & Walsh 2008). In Claire’s case, this is particularly appropriate.

In terms of exploring the evidence base for symptom control. If one uses a biomedical symptom model, then the only significant symptoms are increasing breathlessness, cough and fatigue. There is also an element of insomnia which leads to tiredness during the day. Other, harder to define symptoms, which nevertheless stem from the underlying pathophysiology, but are not generally described in biomedical terms, include her feeling of lack of control of her life, and, by inference there is the issue of her increasing dependence on her husband, Andrew.

If one considers the evidence base for symptomatic treatment, one should ideally first consider the four primary dimensions of palliative care as outlined by Cicely Saunders as they are particularly relevant to Claire, namely the physical, social, spiritual and psychological dimensions. (Saunders & Regnard 1989). It follows that, although this essay will primarily consider symptomatic treatment of breathlessness, it must be understood that this should be delivered within the context of the holistic assessment of the patient discussed in the early paragraphs of this essay. In the words of Valente et al., “ The patient, whole and entire, has relatives, friends, beliefs and previous experiences all of which must be integrated into management strategy.” (Valente & Saunders 2010 Pg 25)

Breathlessness, as a specific symptom, is the result of a complex interaction between the physical body and the conscious mind. It is the most commonly reported symptom found in association with lung cancer and one of the most potentially distressing. (Knower, Dunagan, Adair & Chin 2007).

Breathlessness, unlike the pain commonly associated with malignancies, is difficult to treat with any degree of success. The huge evidence level IIb <https://assignbuster.com/study-of-symptom-management-strategies-for-palliative-care-nursing-essay/>

Higginson trial of lung cancer patients clearly demonstrated that the prevalence of breathlessness rose as death approached and that treatment became progressively more ineffective (Higginson & McCarthy 2008). In another large prospective evidence level IIb study by Edmonds et al. it was found that although clinicians and patients both tend to associate lung cancer primarily with pain, breathlessness has a similar incidence to the extent that 85% patients with lung cancer experienced pain and 78% had significant breathlessness in the last year of their life. (Edmonds, Karlsen, Khan & Addington-Hall 2007)

Treatment of breathlessness is particularly problematic. According to Knowler et al. this is because the symptomatology is both varied and multifactorial. It is not simply a matter of too little tidal volume in the lungs, it is a multisystem disorder with many possible subtle neurohormonal abnormalities and interactions in skeletal and respiratory muscle structure and function. In addition, the experience is extremely subjective with the feeling of breathlessness being modified by not only previous experience of the symptom but also by pathways from a number of different areas within the central nervous system.

Dorman et al. classify malignancy-associated breathlessness into four groups by their different causative mechanisms.

An increase in the sense of respiratory drive or effort to overcome an imposed load (e. g. chronic obstructive pulmonary disease, COPD)

An increase in the proportion of available respiratory muscle force required for breathing, observed in neuromuscular weakness in which respiratory
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motor output and the sense of effort increase (e. g. paraneoplastic syndromes)

An increase in the patient's ventilatory requirements (e. g. anaemia, hypoxaemia)

The contribution of higher cortical experience to the sensation. Memory and previous experience as well as fear and anxiety will all modify the sensation of breathlessness.

(Dorman, Jolley, Abernethy, Currow et al. 2009)

The evidence base for treatment shows that one effective mechanism is to treat any underlying additive cause, such as anaemia, hypoxia or bronchospasm. (Hatley, Laurence, Scott & Thomas 2008)

If one considers the physical elements first, a common factor in the experience of breathlessness in all these circumstances is anxiety. One common effective strategy to reduce the subjective sensation is for the patient to learn relaxation and calm breathing techniques and then to consciously use them whenever they feel anxious and breathless.

Oxygen therapy is frequently useful in relieving the symptoms of breathlessness and the presence of a nasal catheter or mask is often reassuring for the patient. The main evidence base for symptomatic control however, comes from the use of the opioid and benzodiazepine group of medications.

Opiates have by far the strongest evidence base with the evidence level Ib paper by Pharo et al. clearly demonstrating the reduction of both subjective and objective measurements of breathlessness in patients with lung cancer. (Pharo & Zhou 2005). The authors point out that the side effects of opiates, as a class, must be carefully weighed against their probable clinical benefits. Careful examination of the evidence base supporting benzodiazepine use shows that it is less secure. Some authors (viz. Wotton 2004) reporting that they have reduced the sensation of dyspnoea in patients, the majority of randomised controlled trials (viz. Maher, Selecky, Harrod & Benditt 2010,) have not been able to demonstrate any convincing benefit whilst showing significant side effects. They are also known to decrease respiratory drive and compromise lung function, worsening exercise tolerance. (Franco-Bronson 2006). On balance, the evidence base does not support the use of the benzodiazepine group for the relief of breathlessness in malignant disease.

Anxiety and depression, both common associations of malignant disease, are commonly associated with increased perceptions of breathlessness. There is a substantial evidence base to show that aggressive treatment of both can produce significant improvement in subjective assessments of the symptom. Treatment of these conditions are complex and specialised and therefore will not be considered in detail. Kunik et al. have demonstrated in an evidence level IIa study that both anxiolytics (buspirone) and psychological relaxation techniques are capable of producing significant decreases in levels of both anxiety and dyspnoea, as well as improved exercise tolerance among

breathless patients. (Kunik, Azzam, Souchek, Cully, Wray, Krishnan, et al. 2007)

In the interests of providing a comprehensive and balanced argument, note should be taken of the recent evidence level IIa paper by Lewith et al. which noted the positive, but not statistically significant effect of acupuncture on patients suffering from breathlessness. It should also be noted that these were patients with breathlessness as an 'all-cause' symptom rather than specifically from malignant disease. (Lewith, Prescott & Davis 2006)

The evidence base relating to treatment of cough, a common symptom in lung cancer. It is generally taken to indicate involvement of the airways rather than the lung parenchyma, primarily because of the location of cough receptors.

Kvale published a particularly helpful Medline review in 2008 which explored the evidence base for treatment options. (Kvale 2008). The paper itself is both extensive and comprehensive. Confining the discussion to the relevant portions of the paper shows that both surgery and radiotherapy (where appropriate) are both effective in reducing troublesome cough symptoms. A patient undergoing chemotherapy is less likely to have their cough symptoms reduced.

There is a substantial evidence base to support the view that the use of inhaled bronchodilators and corticosteroids can be useful, but not in all cases.

Specific antitussive centrally acting drugs that have been subjected to randomised controlled trials include codeine, hydrocodone, and dextromethorphan. Each of these has a strong supporting evidence base and minimum side effects. Dihydrocodeine has been specifically noted as having the dual purpose of both pain relief and cough suppression. (Homsí, Walsh, & Nelson 2001). The opiate group in general, in addition to relieving pain and breathlessness are also strongly active in cough suppression.

The authors make the point that many trials have noted the cough suppression effect of placebos in randomised controlled trials. This has not only the effect of adding an element of bias into the results, but also offers a line in management of cough in resistant cases.

Fatigue is a common symptom associated with malignancies and certainly with lung cancer. This latter association is postulated to be related to the levels of chronic hypoxia in the later stages of the disease. (Higginson, McCarthy 2008)

The Dagnelie et al. study is particularly useful in this respect as it considered the effect of fatigue on the quality of life of patients with lung cancer and found that it has clear statistical associations with the stage of the disease process, the degree of support that the patient has and also the mental state of the patient. (Dagnelie, Pijls-Johannesn, Lambin & Beijer 2007). They found that those patients who had good support networks, and who were not depressed and who were able to maintain a good level of physical activity were the ones who were least likely to report significant levels of fatigue. A substantive literature search has failed to reveal any good quality trials

which support these findings from a therapeutic perspective but intuitively, one might suggest that including the maintenance of a support network and direct assessment for depressive symptoms into a holistic management plan is likely to reduce levels of fatigue experienced by the patient.

In passing, one can consider the very recent Breitbart study which looked at the use of psycho stimulants in cases of malignancy-related fatigue and found promising results from Modafinil, which is a new category of psychostimulant commonly referred to as wakefulness-promoting agent in the literature. It appears to be well tolerated and with few side effects. The results are too new to have yet been replicated with a larger randomised controlled trial and the authors also point to a large possible placebo effect in their trial. In these circumstances, the evidence base should perhaps be considered 'unproven' until further evidence emerges. (Breitbart & Alici 2010)

The case study makes reference to passing reference to Andrew, Claire's spouse, who retired two years ago and is clearly the main carer in this scenario. He does the shopping, cooking and various other domestic duties for Clare. Although we are told that this makes him feel 'useful' the experienced and empathetic healthcare professional should be aware that the levels of occult depression in cancer-afflicted patient's spouses is extremely high. (Kim, Duberstein, Sorensen & Larson 2005)

It has commonly been found to be the case that as the focus of care and intervention is generally targeted towards the patient, the carers, and

particularly the spouses, do not have their needs either explored, considered or addressed. (Braun, Mikulincer, Rydall, Walsh & Rodin 2007)

It is part of the holistic assessment of the patient's situation that the carers should be actively considered and managed as actively as the patient. This has the direct effect not only of trying to optimise the overall levels of care for the patient, but also promoting the spoken exchange of information, thoughts and feelings which are very likely not to be addressed or recognised, if not explicitly facilitated. (Kim, Schulz & Carver 2007)

The evidence base for these interventions is not strong. There is a considerable evidence base, from a large number of qualitative studies, which underlines the fact that spouses and carers, if supported, can improve the quality of life for the patient. It also appears to be the case that spiritual well being of the patient is improved if spouses and carers are encouraged and facilitated to talk about the situation, especially impending death, which is often regarded as a 'taboo' subject in a household with a patient with a malignancy. Qualitative studies certainly strengthen the evidence base, but, in terms of guidelines and management strategies, they are generally not seen as being as robust as quantitative studies. (Gomm & Davies 2008)

In conclusion, the evidence base to devise a management strategy for Claire is dependent primarily on the mechanisms used to define her symptom base as well as her circumstances. It appears likely that Claire is adapting to her illness trajectory with a minimum of cognitive distortion, and is taking a rather fatalistic view of her situation. Management should clearly be primarily supportive, both of her and her spouse. The evidence base for

symptom control is fairly strong. Pain is not a feature at the moment.

Breathlessness could be tackled, initially by the instigation of anxiety-relieving behaviours and possibly by small doses of opioids. Cough can be helped by the use of dihydrocodeine if it is troublesome and fatigue needs careful evaluation to determine whether there is any depressive or psychological factors which are either primary or additive to the symptomatology.

Claire may also need to be 'given permission' to rest during the day and be told to pace herself with physical activity so that her fatigue is not such a problem for her.

Healthcare professionals need to consider their interventions with the family very carefully. Claire perceives that they 'come out of the woodwork', which suggests that they are an unwelcome reminder of the fact that they are only there because she has a serious and ultimately terminal illness. Claire may need to be encouraged to talk and expand on this issue as the family may find it difficult if they are not welcomed, and Claire may need to be helped to confront the reality of her situation more directly.

Andrew must not be overlooked when constructing a management strategy for this situation. It is a common finding for healthcare professionals to perceive that the spouse is 'being strong', but this may be a façade for their partner. It is a useful strategy for the healthcare professional to make time to talk to Andrew on his own so that he can have the opportunity to raise issues that he may be unclear about. It may be that he does not know what to expect and is uncertain of the best way of handling the situation. Although

possibly premature at the moment, part of the management plan should be to discuss how Andrew is going to approach a worsening situation.

An essay such as this can only realistically consider the situation from a general approach. It is clearly the case that every strategy and intervention should be considered on the basis of a holistic assessment of the individual and the management tailored directly to the specific circumstances of the individual.

Appendix I

Classification of evidence levels

Ia

Evidence obtained from meta-analysis of randomised controlled trials.

Ib

Evidence obtained from at least one randomised controlled trial.

IIa

Evidence obtained from at least one well-designed controlled study without randomisation.

IIb

Evidence obtained from at least one other type of well-designed quasi-experimental study.

III

Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.

IV

Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities.

(SIGN 2001)

Appendix II

Case Details

Clare's general practitioner has just referred her to the community palliative care service. Clare is a 65 year old woman, with lung cancer, an eventually fatal condition. She lives with her husband Andrew in their family home. Her two grown children are married and live interstate.

Clare suffers from breathlessness, cough and fatigue. She gets distressed by her inability to 'catch her breath'. Sometimes she has trouble sleeping at night and is frequently sleepy during the day. Clare says she doesn't have many strategies to help her manage her symptoms. She views her illness as a challenge as it impacts on what she can do and she doesn't feel in control of her life.

Clare tells you that personal relationships are more meaningful for her now and she misses seeing her children, even though she keeps in frequent phone contact. She is surprised by the number of people who have 'come out of the woodwork' and have come to visit her at home.

Andrew retired two years ago so is able to do the shopping, cooking and other domestic duties for him and Clare. He says this makes him feel 'useful' and it's easier for him to do things than to talk about things. Andrew asks you if there is anything more he can do to help Clare.